TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Igor Rakovchik, D.O.

Respondent Name
LM Insurance Corporation

MFDR Tracking Number
M4-17-1450-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
January 17, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Service codes and CPT codes are not to be bundled nor compounded and are to be billed and reimbursed separately and independently from one another… Please note that an office consultation was performed and documented as part of this date of service and should not be bundled or compounded per the CPT Codes as applied to this date of service … [A]n examination was performed and documented as a Detailed Examination component and billed as 99204. See report for all 12 elements required for a general multi-system examination."

Amount in Dispute: $283.16

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We base our payments on the Texas Fee Guidelines and the Texas Department of Insurance Division of Workers' Compensation Acts and Rules."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 10, 2016	Evaluation & Management, new patient (99204)	$251.26	$0.00
September 10, 2016	Needle Electromyography (95886)	$0.00	$0.00
September 10, 2016	Nerve Conduction Studies, 9-10 studies (95911)	$0.00	$0.00
September 10, 2016	Electrodes (A4556)	$16.90	$0.00
September 10, 2016	Needle, sterile, any size, each (A4215)	$15.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 150
   - X263 – The code billed does not meet the level/description of the procedure performed/documented. Consideration will be given with coding that reflects the documented procedure.
   - 234
   - MSCP – In accordance with the CMS Physician Fee Schedule rule for status code "P", this service is not separately reimbursed when billed with other payable services.
   - 97
   - K212 – This procedure is included in another procedure performed on this date.

Issues

1. What are the rules that determine reimbursement for the disputed services?
2. Is LM Insurance Corporation's reason for denial of payment for procedure code 99204 supported?
3. Is LM Insurance Corporation's reason for denial of payment for procedure code A4556 supported?
4. Is LM Insurance Corporation's reason for denial of payment for procedure code A4215 supported?

Findings

1. Igor Rakovchik, D.O. is seeking reimbursement of $283.16 for procedure codes 99204, A4556, and A4215. Dr. Rakovchik included procedure codes 95886 and 95911 on the Medical Fee Dispute Resolution Request (DWC060), but is seeking $0.00 for these procedures; consequently they will not be considered in this dispute. Reimbursement for the disputed codes is subject to the fee guidelines for professional medical services found in 28 Texas Administrative Code §134.203(b)(1), which states, in pertinent part:

   > for coding, billing reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following:
   > (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; … and other payment policies in effect on the date a service is provided…

2. New Hampshire Insurance Company denied procedure code 99204 with claim adjustment reason code X263 – "THE CODE BILLED DOES NOT MEET THE LEVEL/DESCRIPTION OF THE PROCEDURE PERFORMED/DOCUMENTED. CONSIDERATION WILL BE GIVEN WITH CODING THAT REFLECTS THE DOCUMENTED PROCEDURE." The American Medical Association (AMA) CPT code description for 99204 is:

   > Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: **A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity** [emphasis added]. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.

   The 1997 Documentation Guidelines for Evaluation & Management Services, published by the Centers for Medicare and Medicaid Services (CMS) found at https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnedwebguide/downloads/97docguidelines.pdf puts forth the requirements to meet the AMA CPT code description presented. The division will review the submitted documentation to determine if the requirements, as outlined by the 1997 Documentation Guidelines, were met.

Documentation of a Comprehensive History:

	Requirement	Documented Elements	Requirement Met?
Chief Complaint	Statement describing the symptom, etc.	"The examinee presents today with complaints to the following areas: Low back"	Yes
Extended HPI	At least four elements of the HPI.	Location	Yes
		Quality	
		Severity	
		Duration	
		Modifying Factors	
		Musculoskeletal	
		Neurological	
Complete PFSH	At least one specific item from each of the three history areas.	Past	No
		Social	

The Guidelines state, "To qualify for a given type of history all three elements in the table must be met."

Submitted documentation supports the presence of a chief complaint and an extended history. Because the provider documented only two systems, a complete review of systems was not supported. The provider documented two areas of history; therefore, a complete PFSH was not supported for a new patient office visit.

The Division finds that the submitted documentation does not support a Comprehensive Medical History, which is required for procedure code 99204.

Documentation of a Comprehensive Examination:

Dr. Rakovchik argued that the documentation supported "all 12 elements required for a general multi-system examination." The 1997 Documentation Guidelines requires a comprehensive examination to include "a general multi-system examination, or complete examination of a single organ system and other symptomatic or related body area(s) or organ system(s)." A "*comprehensive* examination [for a general multi-system examination] …should include at least nine organ systems or body areas … For each system/area, documentation of at least two elements elements [of the General Multi-System Examination table] is expected."

The requirements for a comprehensive general multi-system examination are evaluated below:

System/Body Area	Documented Elements of Examination	Were At Least 2 Elements Performed?
Constitutional	Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff)	Yes
	General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)	
Musculoskeletal	Examination of gait and station	Yes
	Inspection and/or palpation of digits and nails (e.g. clubbing, cyanosis, inflammatory conditions, petechiae, ischemia, infections, nodes)	
	Examination of joint(s), bone(s), and muscle(s)/tendon(s) of four of the following six areas: 1) head and neck; 2) spine, ribs, and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity.	
	Inspection, percussion and/or palpation with notation of any misalignment, asymetry, crepitation, defects, tenderness, masses or effusions – *1 area*	
	Assessment of range of motion with notation of any pain (e.g., straight leg raising), crepitation or contracture – *1 area*	
	Assessment of stability with notation of any dislocation (luxation), subluxation or laxity – *1 area*	

Skin	Inspection of skin and subcutaneous tissue (e.g., rashes, lesions, ulcers)	No
Neurologic	Examination of deep tendon reflexes with notation of pathological reflexes (e.g., Babinski)	Yes
	Examination of sensation (e.g., by touch, pin, vibration, proprioception)	
Psychiatric	Mood and affect (e.g., depression, anxiety, agitation)	No

Review of the submitted report finds that the required elements were not sufficiently documented. Therefore, submitted documentation does not support a Comprehensive Examination, which is required for procedure code 99204.

Documentation of Decision Making of Moderate Complexity:

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option, as measured by:

- The number of possible diagnoses and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and
- The risk of significant complications, morbidity and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

The submitted report is considered for the presence of the following elements:

- *Number of diagnoses or treatment options*

Problem(s) Status	**Number**	**Documented**
Self-limited or minor (stable, improved or worsening)	Max 2	
Est. problem (to examiner); stable, improved		
Est. problem (to examiner); worsening		
New problem (to examiner); no additional workup planned	Max 1	x
New problem (to examiner); additional workup planned		

Review of the submitted documentation finds that a new problem to the examiner was presented with no additional workup planned, meeting the documentation requirements of moderate complexity. The performance of the electromyography and nerve conduction study was not considered, as the decision to perform this testing was the purpose of the referral and not a result of the examination. Documentation supports that this element was met.

- *Amount and/or complexity of data to be reviewed*

Reviewed Data	**Documented**
Review and/or order of clinical lab tests	
Review and/or order of tests in the radiology section of CPT	
Review and/or order of tests in the medicine section of CPT	
Discussion of test results with the performing physician	
Decision to obtain old records and/or obtain history from someone other than patient	
Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider	x

Independent visualization of image, tracing or specimen itself (not simply review of report)	

Review of the documentation finds that the requestor reviewed and summarized the relevant findings from other providers. The documentation does not support that this element met the criteria for moderate complexity of data reviewed.

- *Risk of complications and/or morbidity or mortality*

  Review of the submitted documentation finds that presenting problems include one acute injury and no ordered procedures or management options selected, which presents a moderate level of risk, per the Table of Risk found in the 1997 Documentation Guidelines. "The highest level of risk in any one category…determines the overall risk." The documentation supports that this element met the criteria for moderate risk.

The 1997 Documentation Guidelines requires that "To qualify for a given type of decision making, **two of the three elements … must be either met or exceeded**." A review of the submitted documentation supports that this component of procedure Code 99204 was met.

Because only one component of CPT Code 99204 was met, Dr. Rakovchik failed to support the level of service required by 28 Texas Administrative Code §134.203. LM Insurance Corporation's denial reason is supported. No additional reimbursement is recommended for this service.

3. LM Insurance Corporation denied procedure code A4556 with claim adjustment reason code MSCP – "IN ACCORDANCE WITH THE CMS PHYSICIAN FEE SCHEDULE RULE FOR STATUS CODE 'P' THIS SERVICE IS NOT SEPARATELY REIMBURSED WHEN BILLED WITH OTHER PAYABLE SERVICES." Medicare policy finds that CPT Code A4556 is a Bundled/Excluded code, which means,

   There are no RVUs and no payment amounts for these services. No separate payment should be made for them under the fee schedule.--If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident. (An example is an elastic bandage furnished by a physician incident to physician service.)--If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (i.e., colostomy supplies) and should be paid under the other payment provision of the Act.

   The Medicare Benefit Policy Manual, Chapter 15 §60.1 states, "Incident to a physician's professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness." The electrodes are incident to the physician services furnished the same day, therefore, they are bundled in those services. LM Insurance Corporation's denial reason is supported. No additional reimbursement is recommended for this service.

4. LM Insurance Corporation denied procedure code A4215 with claim adjustment reason code K212 – "THIS PROCEDURE IS INCLUDED IN ANOTHER PROCEDURE PERFORMED ON THIS DATE." Medicare policy finds that CPT Code A4215 has a status of Statutory Exclusion, which means,

   These codes represent an item or service that is not in the statutory definition of "physician services" for fee schedule payment purposes. No RVUS or payment amounts are shown for these codes, and no payment may be made under the physician fee schedule…

   LM Insurance Corporation's denial reason is supported. No additional reimbursement is recommended for this service.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	March 3, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.